		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039966

Facility Name: BALMORAL HOME

Address: 2055 WEST BALMORAL (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 561-8661 **Fax #** (773) 561-9376

IDPA ID Number: 363902876001

Date of Initial License for Current Owners: 09/10/1993

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford B Alper - Principal

(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C.
1101 Lake Cook Rd, SuiteC, Deerfield, Illnois 60714

(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 213

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	213	Skilled (SNF)	213	77,745	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	213	TOTALS	213	77,745	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	71,093	1,804	1,041	73,938	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,093	1,804	1,041	73,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.10%

D. How many bed-hold days during this year were paid by Public Aid?
1,291 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/10/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 996

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,160	37,849	8,453	227,462		227,462	0	227,462			1
2	Food Purchase		223,182		223,182	(27,302)	195,880	(82)	195,798			2
3	Housekeeping	130,629	13,681	3,722	148,032		148,032	0	148,032			3
4	Laundry	57,151	6,808		63,959	0	63,959	0	63,959			4
5	Heat and Other Utilities			112,988	112,988		112,988	0	112,988			5
6	Maintenance	48,831		46,171	95,002		95,002	77	95,079			6
7	Other (specify):* See Attached			16,666	16,666		16,666	0	16,666			7
8	TOTAL General Services	417,771	281,520	188,000	887,291	(27,302)	859,989	(5)	859,984			8
	B. Health Care and Programs											
9	Medical Director	26,959			26,959		26,959	0	26,959			9
10	Nursing and Medical Records	1,361,662	107,730	2,752	1,472,144		1,472,144	0	1,472,144			10
10a	Therapy	52,419		913	53,332		53,332	0	53,332			10a
11	Activities	130,629	4,835		135,464		135,464	0	135,464			11
12	Social Services	105,256		6,624	111,880		111,880	0	111,880			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,676,925	112,565	10,289	1,799,779	0	1,799,779	0	1,799,779			16
	C. General Administration											
17	Administrative	225,655		19,979	245,634		245,634	0	245,634			17
18	Directors Fees				0		0	0	0			18
19	Professional Services			58,260	58,260		58,260	124	58,384			19
20	Dues, Fees, Subscriptions & Promotions			23,554	23,554		23,554	(6,065)	17,489			20
21	Clerical & General Office Expenses	73,055		25,158	98,213		98,213	1,417	99,630			21
22	Employee Benefits & Payroll Taxes			332,485	332,485	27,302	359,787	16,002	375,789			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar			230	230		230	0	230			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			224,800	224,800		224,800	0	224,800			26
27	Other (specify):*				0		0	0	0			27
28	TOTAL General Administration	298,710	0	684,466	983,176	27,302	1,010,478	11,478	1,021,956			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,393,406	394,085	882,755	3,670,246	0	3,670,246	11,473	3,681,719			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BALMORAL HOME #0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			22,469	22,469		22,469	5,273	27,742			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			47	47		47	(47)	0			32
33	Real Estate Taxes			253,052	253,052		253,052	0	253,052			33
34	Rent-Facility & Grounds			1,252,590	1,252,590		1,252,590	(1,252,590)	0			34
35	Rent-Equipment & Vehicles			10,068	10,068		10,068	0	10,068			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,538,226	1,538,226	0	1,538,226	(1,247,364)	290,862			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		852		852		852	0	852			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			116,618	116,618		116,618	0	116,618			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	852	116,618	117,470	0	117,470	0	117,470			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,393,406	394,937	2,537,599	5,325,942	0	5,325,942	(1,235,891)	4,090,051			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,273	30		9
10	Interest and Other Investment Income	(47)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(82)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(130)	21		18
19	Entertainment				19
20	Contributions	(475)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,599)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(81)	20		28
29	Other-Attach Schedule See Attached Schedule	(6,118)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,259)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,232,632)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,232,632)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,235,891)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BALMORAL HOME

ID# 0039966

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Deductible Dues	$ (5,964)	20	1
2	Franchise Tax	(50)	21	2
3	Franchise Tax	(9)	21	3
4	Trust Fees	(75)	21	4
5	Non Care Related Expenses	(20)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,118)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(82)	0	0	0	0	0	0	0	0	0	0	(82)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	77	0	0	0	0	0	0	0	0	0	77	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(82)	77	0	0	0	0	0	0	0	0	0	(5)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	124	0	0	0	0	0	0	0	0	0	124	19
20	Fees, Subscriptions & Promotions	(6,065)	0	0	0	0	0	0	0	0	0	0	(6,065)	20
21	Clerical & General Office Expenses	(2,338)	3,755	0	0	0	0	0	0	0	0	0	1,417	21
22	Employee Benefits & Payroll Taxes	0	16,002	0	0	0	0	0	0	0	0	0	16,002	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(8,403)	19,881	0	0	0	0	0	0	0	0	0	11,478	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,485)	19,958	0	0	0	0	0	0	0	0	0	11,473	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,273	0	0	0	0	0	0	0	0	0	0	5,273	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(47)	0	0	0	0	0	0	0	0	0	0	(47)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(1,252,590)	0	0	0	0	0	0	0	0	0	(1,252,590)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,226	(1,252,590)	0	0	0	0	0	0	0	0	0	(1,247,364)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,259)	(1,232,632)	0	0	0	0	0	0	0	0	0	(1,235,891)	45

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicag, IL	Nivram Mngt, Inc.	Chicago, IL	Management
Joseph Mermelstein	50.00%	Emerald Park Nursing Home	Evergreen Park, IL			
		Central Nursing Home, Inc.	Chicag, IL			
		Sovereign Healthcare, L.L.C.	Chicag, IL			
		Chicago Ridge Nursing & Rehab Center	Chicago Ridge, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Accounting Fees	$	Nivram Management, Inc.	50.00%	$ 124	$ 124	1
2	V	21	Bank Charges		Nivram Management, Inc.	50.00%	146	146	2
3	V	22	Insurance		Nivram Management, Inc.	50.00%	1,224	1,224	3
4	V	21	Office Expense		Nivram Management, Inc.	50.00%	146	146	4
5	V	6	Repair & Maintenance		Nivram Management, Inc.	50.00%	77	77	5
6	V	21	Supplies		Nivram Management, Inc.	50.00%	2,884	2,883	6
7	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	9	9	7
8	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	14,778	14,778	8
9	V	21	Telephone		Nivram Management, Inc.	50.00%	571	571	9
10	V	34	Rent	1,252,590	Louise Mermelstein	0.00%		(1,252,590)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,252,590			$ 19,959	$ * (1,232,632)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrative Asst.	Administrative	0.00%	227,047	7	9.18%	Salary	$ 22,953	L 17, Col 1	1
2	Louise Meremelstein	Food Serv Superv.	Support	0.00%	73,688	13	18.12%	Salary	16,312	L 1, Col 1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	88,389	3	18.16%	Salary	19,611	L 6, Col 1	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00%	90,999	4	12.13%	Salary	12,561	L 21, Col 1	4
5											5
6	Marvin Mermelstein	Administrative Asst.	Administrative	See Above	132,583	5	18.16%	Salary	29,417	L 17, Col 1	6
7	Joseph Mermelstein	Owner	Administrative	50.00%	71,715	3	24.51%	Salary	23,285	L 17, Col 1	7
8											8
9		See Attached Schedule B									9
10											10
11											11
12											12
13								TOTAL	$ 124,139		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Accounting Fees	Resident Beds	1,173	6	$ 682	$	213	$ 124	1
2	21	Bank Charges	Resident Beds	1,173	6	805		213	146	2
3	22	Insurance	Resident Beds	1,173	6	6,740		213	1,224	3
4	21	Office Expense	Resident Beds	1,173	6	805		213	146	4
5	6	Repairs & Maintenance	Resident Beds	1,173	6	424		213	77	5
6	21	Supplies	Resident Beds	1,173	6	15,880		213	2,883	6
7	21	Franchise Tax	Resident Beds	1,173	6	50		213	9	7
8	22	Payroll Taxes	Resident Beds	1,173	6	81,386		213	14,778	8
9	21	Telephone	Resident Beds	1,173	6	3,145		213	571	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,917	$		$ 19,958	25

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10	State Repl Tax Refund										47	10
11	Offset Interest Income										(47)	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 130,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 243,052	2
3. Under or (over) accrual (line 2 minus line 1).		$ 113,052	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 140,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 253,052	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	248,480	8
	1998	249,874	9
	1999	247,197	10
	2000	236,891	11
	2001	243,052	12

2001 Tax Bill = 243,052.28
Estimated Increase = 1.03%
Estimated Tax = (250,344 Less 110,000 Overpayment) = 140,344
Rounded = 140,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BALMORAL HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0039966

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (773) 580-4100 FAX #: (773) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-07-109-036-0000	Nursing Home	$ 243,052.28	$ 243,052.28
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 243,052.28	$ 243,052.28

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,360 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	33,375	1993	$ 90,430	1
2					2
3	TOTALS	33,375		$ 90,430	3

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	213		1993	1968	$ 985,048	$	30	$	$	$ 985,048	4
5					(35,470)						5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1994	8,500	218	35	243	25	2,106	9
10	Fence			1994	2,700	69	35	77	8	591	10
11	Leasehold Improvements			1995	4,813	123	10	481	358	3,688	11
12	Leasehold Improvements			1995	3,750		10	375	375	2,875	12
13	Fire Alarm			1996	8,750	224	15	584	360	3,893	13
14	Laundry Chute			1996	2,181	56	15	146	90	973	14
15	Concrete Ramp			1996	2,500	64	35	72	8	480	15
16	Phone System			1993	4,475		5			4,475	16
17	Time Clock System			1993	1,853		5			1,853	17
18	Carpet			1993	1,144		5			1,144	18
19	Phone System			1994	2,967		5			2,967	19
20	Hot Water Heater			1995	3,035		5			3,035	20
21	Awning and Signs			1997	5,923	152	39	152		861	21
22	Parking Lot			1997	6,600	330	15	440	110	2,493	22
23	Remodeling Loundry Area			1997	5,399	138	7	772	634	4,375	23
24	Remodeling Loundry Area			1997	19,779	507	7	2,826	2,319	9,714	24
25	Handrails			1997	5,750	147	7	822	675	4,658	25
26	Fire Alarm			1997	16,726	428	7	2,390	1,962	13,543	26
27	Light Fixtures			1997	6,552	669	7	936	267	5,304	27
28	Boiler			1997	925	24	7	132	108	724	28
29	Kitchen Improvements			1997	2,875	74	7	410	336	2,323	29
30	Elevator			1997	2,300	59	7	328	269	1,859	30
31	Bathroom Remodeling			1997	312	8	7	44	36	249	31
32	HVAC, Boiler			1998	14,915	382	7	2,131	1,749	9,944	32
33	Ward Doors			1998	2,803	72	35	80	8	373	33
34	Concrete Steps			1998	2,500	64	35	71	7	332	34
35	Fire Alarm			1999	16,000	410	10	1,600	1,190	5,867	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler and Ductowrk	1999	$ 18,500	$ 474	10	$ 1,850	$ 1,376	$ 6,783	37
38	Windows	1999	1,498	38	10	150	112	550	38
39	Cooling Tower	2000	8,860	227	10	886	659	2,363	39
40	Heater	2000	3,000	77	10	300	223	800	40
41	Vestibule Remodeling	2001	4,200	108	39	108		171	41
42	Elevator	2002	1,500	34	39	19	(15)	19	42
43	Carpet	2002	1,500	34	39	19	(15)	19	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,144,663	$ 5,210		$ 18,444	$ 13,234	$ 1,086,452	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 87,758	$ 6,815	$ 8,776	$ 1,961	5-10 Yrs	$ 29,808	71
72	Current Year Purchases	10,444	10,444	522	(9,922)	10 Years	522	72
73	Fully Depreciated Assets	65,971			0		65,971	73
74					0			74
75	TOTALS	$ 164,173	$ 17,259	$ 9,298	$ (7,961)		$ 96,301	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,399,266	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 22,469	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 27,742	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,273	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,182,753	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,695 Description: Icemaker - $900; Copier - $1,795
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Faculty Vehicle	1999 Chevy Tahoe	$ 463.00	$ 2,162	17
18	Faculty Vehicle	2002 Chevy Tahoe	579.00	5,211	18
19					19
20					20
21	TOTAL		$ 1,042.00	$ 7,373	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 10, Col 2	# of prescrpts				31,987		31,987	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Attached Sch A						3,839		3,839	13
14	TOTAL			$		$	$ 35,826		$ 35,826	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (73,824)	$ (73,824)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	539,741	539,741	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	59,487	59,487	6
7	Other Prepaid Expenses	38,657	38,657	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Loan Rec - Employees	63,600	63,600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 627,661	$ 627,661	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,430	13
14	Buildings, at Historical Cost		985,048	14
15	Leasehold Improvements, at Historical Cost	172,810	172,810	15
16	Equipment, at Historical Cost	186,448	186,448	16
17	Accumulated Depreciation (book methods)	(202,449)	(1,187,497)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	5,774	5,774	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 162,583	$ 253,013	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 790,244	$ 880,674	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 26,710	$ 26,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	140,000	140,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,982	10,982	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	280,377	280,377	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 458,069	$ 458,069	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 458,069	$ 458,069	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 332,175	$ 422,605	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 790,244	$ 880,674	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,029,839	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,029,839	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,418,736	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,116,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (697,664)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 332,175	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,670,226	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,670,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	34,975	6
7	Oxygen	9,446	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,421	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,032	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,471	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,471	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Attached Schedule	24,046	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 24,046	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,777,196	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	887,291	31
32	Health Care	1,799,779	32
33	General Administration	983,176	33
	B. Capital Expense		
34	Ownership	1,538,226	34
	C. Ancillary Expense		
35	Special Cost Centers	852	35
36	Provider Participation Fee	116,618	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,325,942	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,451,254	41
42	**Income Taxes**	(32,518)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,418,736	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,484	3,524	$ 101,186	$ 28.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,514	31,050	616,280	19.85	3
4	Licensed Practical Nurses	3,239	3,479	53,745	15.45	4
5	Nurse Aides & Orderlies	73,780	76,241	590,453	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,433	3,649	52,419	14.37	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,038	2,262	25,440	11.25	9
10	Activity Assistants	5,113	5,149	42,728	8.30	10
11	Social Service Workers	8,306	8,741	105,256	12.04	11
12	Dietician					12
13	Food Service Supervisor	2,795	2,891	36,806	12.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,564	20,867	144,353	6.92	15
16	Dishwashers					16
17	Maintenance Workers	2,529	2,625	48,831	18.60	17
18	Housekeepers	18,120	19,198	130,629	6.80	18
19	Laundry	7,270	7,766	57,151	7.36	19
20	Administrator	934	934	150,000	160.60	20
21	Assistant Administrator	791	791	75,655	95.64	21
22	Other Administrative					22
23	Office Manager	223	223	12,561	56.33	23
24	Clerical	5,178	5,259	60,494	11.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,207	4,479	62,460	13.95	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,016	2,240	26,959	12.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,534	201,368	$ 2,393,406 *	$ 11.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,453	L 1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	2,752	L 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	10	480	L 10A, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	7	433	L 10A, Col 3	43
44	Activity Consultant				44
45	Social Service Consultant	50	6,624	L 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	67	$ 18,742		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marvin Mermelstein	Asst. Administrator	50.00%	$ 29,417
Barry Taerbaum	Administrator	0.00%	150,000
Henry Mermelstien	Administrative	0.00%	22,953
Joseph Mermelstein	Administrative	50.00%	23,285
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 225,655

B. Administrative - Other

Description	Amount
Management Fees	$ 19,979
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 19,979

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule		58,260
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 58,260

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,500
Unemployment Compensation Insurance	13,861
FICA Taxes	164,327
Employee Health Insurance	92,490
Employee Meals	27,302
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	4,324
Other Employee Benefits	22,888
Union Health & Wealfare	9,095
Allocation from Management Company	16,002
TOTAL (agree to Schedule V, line 22, col.8)	$ 375,789

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	7,347
Health Care Worker Background Check (Indicate # of checks performed 307)	2,150
See Attached Schedule	7,673
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(81)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,489

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	230
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 230

**See instructions.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $11,834**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **359** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **116,618**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **27,302** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0.00%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees